



Member Schedule

Benefits are available In-Network and Out-of-Network.

Employer's Name:

Client Number:

Client Effective Date:

Group Number:

Anniversary Date:

Coverage Effective Date:

Benefit Period:



DEDUCTIBLE

Network Providers – per Member per Benefit Period and per family per Benefit Period. With family coverage, once one Member meets a Deductible, benefits will begin paying for that Member.

Out-of-Network Provider – per Member or per Family per Benefit Period.

The In-Network and Out-of-Network amounts do not apply to each other. The Deductible applies to the Maximum Out-of-Pocket.

The Deductible applies to all Covered Services except Preventive Care and Primary Care Physician Office visit when the Copayment applies to that visit. The Deductible applies to the Maximum Out-of-pocket.



COINSURANCE

Network Providers – The Percentage of the Allowed Amount that you pay for Covered Services. You pay of the Allowed Amount until you reach the Maximum Out-of-pocket.

Out-of-Network Providers – You pay of the



COPAYMENTS

No Copayments for this Plan



MAXIMUM OUT-OF-POCKET

Network Providers – per Member per Benefit Period and per family per Benefit Period Covered Services will be paid at of the Allowable Charges when you reach your Maximum Out-of-pocket. With family coverage, once one Member meets a Maximum Out-of-Pocket, benefits are payable at for that Member only.

Out-of-Network Providers – per member or Family per Benefit Period.

The In-Network and Out-of-Network amounts do not apply to each other. Covered Service will be paid at 100% from Network Providers after the Out-of-Pocket Limit is met.

The Maximum Out-of-pocket includes Copayments, Deductibles and Coinsurance. It does not include Premiums, Balance-billed charges or health care this Policy does not cover.



PRESCRIPTION DRUG COVERAGE

In-Network Retail: 31 days supply maximum

Tier 0:
Tier 1:
Tier 2:
Tier 3:
Tier 4:

Out-of-Network Retail:

Tier 0:
Tier 1/2/3:
Tier 4:

In-Network Retail Mail-Order: 90 day supply

Tier 0:
Tier 1:
Tier 2:
Tier 3:
Tier 4:

Out-of-Network Retail:

Some drugs are considered specialty medications and must be filled at our Specialty Pharmacy, OptumRx® Specialty Services. Although most specialty drugs are found in Tier 4, they could be Tier 1, 2 or 3. Please see your Certificate for a description of the Tiers for further clarification. Also see the Business BlueEssentials Covered Drug List for the list of drugs that must be filled with the Specialty Pharmacy.

BENEFIT PERIOD MAXIMUM — Per Member Per Benefit Period

60 days for Skilled Nursing Facility

60 visits for Home Health Care

6 months per episode for Inpatient and Outpatient Hospice Care

30 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined

30 Habilitative visits for Physical, Speech and Occupational Therapy Services combined

\$500 Sustained Health Benefit for physical exam services not included in other Preventive Screenings

\$500 Spinal Subluxation (Chiropractic Services) Benefit if Endorsement is purchased

All benefits payable on Covered Services are based on our allowed amount. All covered services must be medically necessary. Some services require preauthorization, including all hospital admissions, except maternity. See the preauthorization section of the Certificate for information concerning the preauthorization requirement.

For some services to be covered, you will be required to use a provider we designate, who may or may not be a Business BlueEssentials provider. These services include transplants, mammography, habilitation, rehabilitation and vision care.

This Contract is intended to be used as a "qualified high deductible health plan" under Section 223 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. See Certificate of Coverage for more detailed information.

Our plan has free language interpretation services available. We can also give you information in languages other than English, in large print or other alternate formats.

Services That Are Covered For You



PRIMARY CARE PHYSICIAN, SPECIALIST OR URGENT CARE CENTERS

Office Visit Services – All office charges for the treatment of illness, accident or injury with the exception of diagnostic services such as MRIs, MRAs, PET Scans, CT Scans, and other diagnostic scans. Includes mental health and substance use disorder services.

Blue CareOnDemandSM

Inpatient Physician and Surgical Services

All Other Physician Services – Outpatient hospital; skilled nursing facility; clinics; lab, X-ray, and the reading/interpretation of diagnostic lab and X-ray services; surgery, male sterilization; second surgical opinion; consultation; anesthesia; dialysis treatment, chemotherapy, radiation therapy and the administration of specialty medications.

Urgent Care Center – The facility must be licensed as an urgent care center.

In-Network

Out-of-Network



PREVENTIVE CARE FOR CHILDREN AND ADULTS

As outlined in your Contract as Preventive Care benefits. Includes some contraceptive devices or services.



There are No Benefits for Preventive Care Out-of-Network.

All other covered contraceptive devices or services not specifically listed in your Contract.

Services related to a physical exam not included in other covered Preventive Screenings limited to \$500 per Benefit Period. Services may be subject to age and visit limits.

Services and benefits are included for Chiropractic Services limited to \$500 per Benefit Period if Endorsement is purchased.



There are No Benefits for Sustained Health or Chiropractic Services Out-of-Network.

In-Network

Out-of-Network



LABORATORY AND DIAGNOSTIC SERVICES

Radiology, ultrasound and nuclear medicine; laboratory and pathology; ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing; Endoscopies (such as colonoscopy, proctoscopy and laparoscopy); high technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, cardiac catheterizations and procedures performed with contrast or dye.

In-Network

Out-of-Network



HOSPITAL SERVICES

Inpatient and outpatient Hospital (other than Skilled Nursing Facilities, Rehabilitation Facilities or Emergency Room). Includes Mental Health and Substance Use Disorder Services.

Ambulatory Surgical Center (ASC) facility charge - An ASC is a free-standing facility not affiliated with a health system that is licensed for Outpatient Services only and doesn't provide overnight accommodations or around-the-clock care.

In-Network

Out-of-Network



EMERGENCY SERVICES

Emergency room charges in- or out-of-network or out-of-area, including physician services in the Emergency Room (copayment applies only to Emergency Room charges)

Ambulance services in- or out-of-network or out-of-area, only when medically necessary

In-Network

Out-of-Network



MATERNITY

Pre- and post-partum care including Physician services. Hospital services provided as shown above.

Expecting a new baby? Our free Maternity Care program can provide you with the tools and information you need to help get your baby off to a healthy start. To enroll, call 855-838-5897 and select option 4.

In-Network

Out-of-Network



NEWBORN CARE

Post-natal care, including physician services. Hospital services provided as shown above. Benefits are available only if the child is added to your policy.

In-Network

Out-of-Network



REHABILITATIVE AND HABILITATIVE

Durable Medical Equipment (DME) - purchase or rental - excludes repair of, replacement of and duplicate DME.



There are no Out-of-Network benefits for DME

Physical, occupational, speech and respiratory therapy

Rehabilitation including cardiac and pulmonary

Skilled nursing and rehabilitation facilities

Medical supplies

In-Network

Out-of-Network



MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

- Inpatient and physician's services
- Outpatient and physician's services
- Residential treatment centers
- Physician's office (same as Primary Care Physician (PCP) Office visit)
- Autism Spectrum Disorder - Behavioral Therapy. Preauthorization is required

In-Network	Out-of-Network



OTHER SERVICES

- Dental Services Related to Accidental Injury – Only when such care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring through the natural act of chewing). It's limited to care completed within six months of such accident and while the patient is still covered under this policy.
- Home health care (60-visit maximum)
- Hospice care (6 months per episode to include Inpatient and Outpatient care)
- Out-of-Country services including facility and physician for emergency and urgent care only, if covered through a BlueCard[®] provider.

In-Network	Out-of-Network